STATE OF MICHIGAN

COURT OF APPEALS

SETH NEBLETT, Personal Representative of the Estate of SARAH C. FRANKLIN, Deceased,

Plaintiff-Appellant/Cross-Appellee,

v

HENRY FORD HEALTH SYSTEMS, DR. SHAMLOO, DR. RAJAT PRAKASH, DR. AREF AMRO, POLLY MCGREEVY, MARY KLIP, DENISE ALLAR, VENTAS, INC., and TRANSITIONAL HOSPITAL CORPORATION OF MICHIGAN, d/b/a KINDRED HOSPITAL METRO DETROIT, KINDRED HOSPITAL EAST, L.L.C., and KINDRED HOSPITAL DETROIT,

Defendants-Appellees,

and

KINDRED HEALTHCARE, INC., f/k/a VENCOR, INC.,

Defendant-Appellee/Cross-Appellant,

and

HENRY FORD MEDICAL CENTER and DR. RONALD FOGEL,

Defendants.

UNPUBLISHED
January 31, 2006

No. 256803
Wayne Circuit Court
LC No. 00-039874-NH

Before: Murray, P.J., and Jansen and Kelly, JJ.

PER CURIAM.

Plaintiff Seth Neblett ("plaintiff"), Personal Representative of the Estate of Sarah C. Franklin ("decedent"), appeals as of right two orders granting defendants' motions for summary

disposition in this medical malpractice action. Defendant Kindred Healthcare, Inc. ("Kindred"), cross-appeals as of right an order denying Kindred's motion for summary disposition based on the statute of limitations. We affirm in part and reverse in part.

Plaintiff first argues that the trial court erred in granting summary disposition on the basis that his medical malpractice claim lacked sufficient proof of causation. We disagree.

We review a trial court's ruling on a motion for summary disposition de novo. *Ormsby v Capital Welding, Inc*, 471 Mich 45, 52; 684 NW2d 320 (2004). A motion made under MCR 2.116(C)(10) tests the factual support for a claim, *Dressel v Ameribank*, 468 Mich 557, 561; 664 NW2d 151 (2003), and should be granted when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law, *Miller v Purcell*, 246 Mich App 244, 246; 631 NW2d 760 (2001). When the burden of proof at trial would rest on the nonmoving party, the nonmovant may not rest upon mere allegations or denials in the pleadings, but must, by documentary evidence, set forth specific facts showing that there is a genuine issue for trial. *Quinto v Cross & Peters Co*, 451 Mich 358, 362; 547 NW2d 314 (1996); *Karbel v Comerica Bank*, 247 Mich App 90, 97; 635 NW2d 69 (2001). A genuine issue of material fact exists when the record, drawing all reasonable inferences in favor of the nonmoving party, leaves open an issue upon which reasonable minds could differ. *West v GMC*, 469 Mich 177, 183; 665 NW2d 468 (2003). When deciding a motion for summary disposition under this rule, a court must consider the pleadings, affidavits, depositions, admissions, and other documentary evidence then submitted by the parties in the light most favorable to the nonmoving party. MCR 2.116(G)(5); *Ritchie-Gamester v City of Berkley*, 461 Mich 73, 76; 597 NW2d 517 (1999).

To establish medical negligence, "the plaintiff has the burden of proving that . . . [t]he defendant, if a specialist, failed to provide the recognized standard of practice or care . . . ." MCL 600.2912a(1)(b). Then "the plaintiff has the burden of proving that . . . as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury." MCL 600.2912a(1)(b). To establish proximate causation, "the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants." MCL 600.2912a(2).

"'Proximate cause' is a legal term of art that incorporates both cause in fact and legal (or 'proximate') cause." *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). Cause in fact requires plaintiff to show that but for the defendant's actions, the injury would not have occurred, while legal or proximate cause normally involves examining the foreseeability of consequences. *Id.* at 86-87. Cause in fact requires more than a possibility of causation:

> It is important to bear in mind that a plaintiff cannot satisfy this burden by showing only that the defendant *may* have caused his injuries. Our case law requires more than a mere possibility or a plausible explanation. Rather, a plaintiff establishes that the defendant's conduct was a cause in fact of his injuries only if he sets forth specific facts that would support a reasonable inference of a logical sequence of cause and effect. A valid theory of causation, therefore, must be based on facts in evidence. And while the evidence need not negate all other possible causes, . . . [it must] exclude other reasonable hypotheses with a fair amount of certainty. [*Craig, supra* at 87-88 (internal quotation marks, brackets and footnotes omitted).]

The trial court characterized plaintiff's allegations of causation as being "that the decedent's hypotension led to gastric erosions which in turn led to congestive heart failure." Thus, the question was whether plaintiff submitted any evidence that created a genuine issue of material fact on this issue of causation.

Plaintiff cites Dr. Michael White's and Dr. Werner Spitz's deposition testimony, but his citations to Dr. White's deposition contain no testimony bearing on causation. Therefore, the trial court correctly found that Dr. Spitz's testimony was the only testimony bearing on causation.

When asked whether gastric erosions played a role in decedent's death, Dr. Spitz testified that "the gastric erosions contribute to hemorrhage, and if they contribute to hemorrhage, they contribute to further lowering or maybe previously existing low hemoglobin already and contribute to the fact that she is in congestive heart failure." The trial court noted the ambiguity in this testimony. Dr. Spitz's statement indicates that "if" gastric erosions contribute to hemorrhage, this lowers already low hemoglobin, which "contribute[s] to the fact that [the decedent] is [already] in congestive heart failure." This opinion is hypothetical; it does not indicate actual factual causation.

Dr. Spitz, who performed an autopsy of decedent, opined that decedent died of congestive heart failure, and acknowledged that there are "a lot of possibilities" for causes of congestive heart failure. When asked for his opinion on what caused decedent's congestive heart failure, Dr. Spitz again responded in hypothetical terms:

> *Q*. Do you have an opinion in this case what caused Mrs. Franklin's [congestive heart failure]?
>
> *A*. Well, as I'm told, that a hemoglobin of 5.5 if it extends for a lengthy period, that may be the reason for it.

Thus, Dr. Spitz's causation opinion was (1) based on what he was told, and (2) tentative, insofar as a hemoglobin reading of 5.5, "if" it is extended, "may" be a cause of congestive heart failure. As such, Dr. Spitz's testimony is insufficient to satisfy the required standard of causation. See *Craig*, *supra* at 87-88.

The trial court noted that under plaintiff's apparent theory of causation "there has to be a showing of low hemoglobin over a significant period of time, apparently, in the range of 5.5," and noted the following testimony by Dr. Spitz:

> *Q*. Okay. Have we now covered your entire opinion in regard to the cause of death of Miss Franklin?
>
> ***
>
> *A*. . . . I'm not talking about various connections right now. All I'm saying is that when for whatever reason, *if it is established that the hemoglobin is down to around five or between five and six, and that this situation prevails for a lengthy period of time and that there is, in fact, a connection between the*

> *various links in this case*, between the low hemoglobin and the onset of congestive heart failure, that it has to be conceded that there is a connection between low hemoglobin, low. . . oxygen carrying capacity of the blood and congestive heart failure, and that this would aggravate pre-existing coronary artery disease, arteriosclerotic coronary artery disease because the heart already gets little blood perfusion and it would get less blood perfusion in the case of congestive heart failure and low hemoglobin, so it seems to all tie together, but as I said, I'm unaware of the timely episodes here. [Emphasis added.]

The trial court noted that Dr. Spitz responded to the question hypothetically, and that "it is not really clear that he reached a conclusion that the congestive heart failure here resulted in this case from low hemoglobin." That conclusion was sound. Dr. Spitz opined hypothetically by saying "*if it is established that* the hemoglobin is down . . . *and that* this situation prevails for a lengthy period of time *and that there is, in fact, a connection between the various links in this case,*" then certain things would follow. By so testifying, Dr. Spitz did not opine that there was, in fact, low hemoglobin, that it was in fact prolonged, or that there was, in fact, a connection between the various links in this case. Thus, the trial court correctly concluded that Dr. Spitz did not testify that the congestive heart failure in fact resulted from low hemoglobin.

The trial court next examined whether there was evidence of low hemoglobin, "between five and six . . . for a lengthy period of time," and detailed the hemoglobin levels, only three of which were between five and six. During decedent's initial stay at Henry Ford Health System (HFHS) from March 4, 1988, through April 11, 1998, decedent's hemoglobin fell below six only once, on March 4, 1998. After decedent's return to HFHS on June 11, 1998, until her demise on May 5, 2002, decedent's hemoglobin dropped below six only once, on October 10, 1998. Decedent's hemoglobin never fell to 5.5, the level which, according to Dr. Spitz, if sustained for a long period, "may" be a reason for decedent's congestive heart failure. From October 10, 1998, until decedent's death, her hemoglobin never fell below six. In addition to the two instances of low hemoglobin being temporally distant from decedent's demise, there is no evidence that two instances of low hemoglobin in 1998 played any causal role in decedent's death. Accordingly, vis-à-vis HFHS, the trial court correctly concluded that plaintiff failed to raise a genuine issue of material fact regarding causation in fact.

The next issue is whether plaintiff presented sufficient evidence of causation vis-à-vis Kindred. During decedent's stay at Kindred, toward the latter part of her hospitalization, she again became significantly anemic. She clinically stabilized and remained stable on ventilator support, but experienced repeated drops in hemoglobin. Here too, the drops in hemoglobin while decedent was at Kindred were temporally removed from decedent's death four years later, and plaintiff presented no evidence that drops in hemoglobin in 1998 at Kindred played a causal role in decedent's death. Accordingly, vis-à-vis Kindred, the trial court correctly concluded that plaintiff failed to raise a genuine issue of fact regarding causation in fact. Based on Dr. Spitz's testimony and the record of hemoglobin levels, and considering the evidence in a light favorable to plaintiff, the trial court correctly concluded that plaintiff failed to show that it was more probable than not that decedent's congestive heart failure resulted from any defendant's medical malpractice.

Plaintiff next argues that the trial court erred in dismissing his vicarious liability claims against Kindred and HFHS, and his direct liability claim against HFHS. We disagree.

For a hospital to be held liable under a theory of vicarious liability, the plaintiff must prove that agents of the hospital breached the applicable standard of care. *Cox v Flint Bd of Hosp Mgrs*, 467 Mich 1, 5, 11; 651 NW2d 356 (2002). Because plaintiff lacks proof that malpractice by any defendant was a cause in fact of decedent's death, there can be no vicarious liability.

In addition to vicarious liability, "[a] hospital may be . . . directly liable for malpractice, through claims of negligence in supervision of staff physicians as well as selection and retention of medical staff." *Cox, supra* at 11. Here, plaintiff's July 3, 2003, complaint asserts:

> Defendant Henry Ford Health System failed to timely exercise due care and skill in the selection, training and/or supervision of [its] staff, interns, residents, including but not limited to, Ann Childress, and/or permitted Defendant doctors to remain on [its] staff or permitted them to be on [its] staff, and/or permitted them to have privileges when same were unfit and/or inexperienced to render such medical care.

On appeal, however, plaintiff presents no evidence to support a claim against HFHS for negligent supervision, selection and retention of medical staff. The trial court did not err in dismissing the vicarious liability claims against Kindred and HFHS, and the direct liability claim against HFHS.

Plaintiff next argues that the trial court erred in dismissing his claims against the HFHS social workers. We disagree.

Although plaintiff argues that on November 10, 2000, the trial court ruled that the claims against the social workers did not need to be supported by an affidavit of merit, plaintiff failed to produce the transcript of the November 10, 2000, hearing, making it difficult for this Court to properly assess plaintiff's argument. Additionally, the hearing on November 10, 2000, was in a different case, LC No. 00-030379-NH, and plaintiff presents no argument why that ruling should be binding in the case at bar. This Court is not obliged to divine plaintiff's argument, brief the issue for plaintiff, and locate authority for it. *Tingley v 900 Monroe, LLC*, 266 Mich App 233, 245-246, 255-256; __ NW2d __ (2005). Finally, plaintiff presents no order entered by the court as a result of the November 10, 2000, hearing, and because courts only speak through their written orders, *In re Gazella*, 264 Mich App 668, 677; 692 NW2d 708 (2005), there is nothing for us to review.

The issue here is whether plaintiff's claims against the social workers sounded in medical malpractice. "The fact that an employee of a licensed health care facility was engaging in medical care at the time the alleged negligence occurred means that the plaintiff's claim may *possibly* sound in medical malpractice." *Bryant v Oakpointe Villa*, 471 Mich 411, 421; 684 NW2d 864 (2004). "A complaint cannot avoid the application of the procedural requirements of a malpractice action by couching its cause of action in terms of ordinary negligence." *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488, 509; 668 NW2d 402 (2003) (citation omitted). To determine whether a claim sounds in medical malpractice, the court looks for two defining

characteristics. "First, medical malpractice can occur only within the course of a professional relationship." *Bryant, supra* at 422 (citation omitted). "Second, claims of medical malpractice necessarily raise questions involving medical judgment" that are not "within the common knowledge and experience of the fact-finder." *Id*. (citations omitted).

> Therefore, a court must ask two fundamental questions in determining whether a claim sounds in ordinary negligence or medical malpractice: (1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience. [*Bryant, supra* at 422.]

Here, the claims against the social workers pertain to actions by the social workers that occurred within the course of a professional relationship between HFHS (and its employees) and decedent, because decedent was a patient at HFHS. Thus, the first requirement for finding a medical malpractice claim is satisfied.

The next question is whether plaintiff's claims raise questions of medical judgment. Plaintiff's July 3, 2003, complaint states three counts: (I) general negligence and medical malpractice; (II) negligent and/or intentional misrepresentation; and (III) intentional infliction of emotional distress. Count I makes only general allegations directed at the social workers. A majority of the allegations in count I relate to medical care provided to decedent. Plaintiff alleges that HFHS and its agents "owed to the general public and to Plaintiff in particular, a duty of due care *to conform with the applicable standard of practice in the treatment of their patient* such as Sarah Franklin." For specifics, plaintiff alleges such things as that HFHS "failed to keep accurate Medical Records for Plaintiff"; "owed a duty to communicate truthfully regarding Sarah Franklin's condition" but "communicated falsely in this regard"; told decedent "she was being taken outside to the street causing extreme anxiety"; and "falsely accused Sarah's daughter Jenifer of having a gun at the hospital and threatening to kill her mother Sarah." Plaintiff makes no allegations in count I indicating that the social workers did any acts unrelated to the hospitalization, care and treatment of decedent, and a majority of the allegations in count I relate to medical issues, such as diagnosis, medical monitoring of decedent, her hemoglobin levels, gastrointestinal bleeding, and whether decedent should have been transferred to Kindred. Such issues are beyond the ken of ordinary laymen not trained in medicine. Accordingly, the issues raised by the allegations in count I raise questions of medical judgment, and count I sounds in medical malpractice.

Count II exclusively discusses communications relating to decedent's condition. For instance, count II alleges that HFHS employees, by misrepresenting decedent's condition, were able to obtain consent to transfer decedent to Kindred; that HFHS "failed to communicate truthfully & fully to Vencor [i.e., Kindred] and/or Sarah's family regarding the physical needs of Sarah"; and that the HFHS physician who prepared decedent's death certificate "did not reveal Sarah's G.I. Bleed, as a significant condition." These and all of the many other allegations in count II relate to the medical care provided to decedent. These allegations raise questions of medical judgment. An ordinary layperson cannot judge whether a patient was appropriately transferred from a hospital like HFHS to a lesser facility like Kindred; whether statements by hospital staff accurately reflected the patient's condition; or whether the patient's GI bleed had in fact resolved. Accordingly, count II raised questions of medical judgment.

Count III makes numerous additional allegations, including that HFHS staff told decedent "she was being taken outside to the street"; told decedent that her daughter, Jenifer Franklin, was carrying a gun at the hospital and was threatening to kill decedent; that HFHS pressured the family to "no code" decedent and threatened to "have her terminally removed from the vent." These and the other acts complained of in count III occurred within the course of the professional relationship between the hospital and decedent. These allegations raise questions of medical judgment. Whether a patient will be discharged, removed from a "code" status, or removed from a ventilator, are questions requiring education, training and experience in medicine, on which an untrained layperson cannot opine. Accordingly, count III also sounded in medical malpractice.

Because the claims against the social workers pertain to actions that occurred within the course of a professional relationship and raise questions of medical judgment, these claims are "subject to the procedural and substantive requirements that govern medical malpractice actions." *Bryant, supra* at 422. Among those requirements is MCL 600.2912d, which requires that plaintiff file with the complaint an affidavit of merit from an expert who meets the requirements of MCL 600.2169. Here, plaintiff did not file with the complaint an affidavit of merit from a social worker. Accordingly, the trial court correctly dismissed these claims.

The next issue is Kindred's argument that the trial court erroneously denied Kindred summary disposition under MCR 2.116(C)(7) because plaintiff's amended complaint and affidavit of merit were not timely filed under the statute of limitations, and the previously filed affidavit of merit was grossly nonconforming.[1] We agree.

This Court reviews de novo whether a statute of limitations bars a claim. *Farley v Advanced Cardiovascular*, 266 Mich App 566, 570-571; 703 NW2d 115 (2005). "A motion under MCR 2.116(C)(7) may be supported by affidavits, admissions, or other documentary evidence and, if submitted, such evidence must be considered by the court." *Travelers Ins Co v Guardian Alarm*, 231 Mich App 473, 477; 586 NW2d 760 (1998). "[T]he court must take all well-pleaded allegations as true and construe them in favor of the nonmoving party." *Id.* "If there are no facts in dispute, whether the claim is statutorily barred is a question of law for the court." *Id.*

MCL 600.5805 provides the limitations period for a medical malpractice claim or action:

> (1) A person shall not bring or maintain an action to recover damages for injuries to persons or property unless, after the claim first accrued . . . the action is commenced within the periods prescribed by this section.
>
> ***
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> (6) . . . the period of limitations is 2 years for an action charging malpractice. . . . [MCL 600.5805.]

[1] Plaintiff's claim against Kindred also fails as a matter of law for the same reasons just discussed regarding proximate cause.

When an action is "commenced" is somewhat different for medical malpractice claims. "[M]edical malpractice plaintiffs must file more than a complaint; they 'shall file with the complaint an affidavit of merit . . . .' MCL 600.2912d(1)." *Scarsella v Pollack*, 461 Mich 547, 549; 607 NW2d 711 (2000). Thus, "for statute of limitations purposes in a medical malpractice case, the mere tendering of a complaint without the required affidavit of merit is insufficient to commence the lawsuit." *Id*.

Assuming that plaintiff filed an affidavit of merit with his complaint, the affidavit of merit was invalid and nonconforming. A plaintiff who fails to file with the complaint a valid affidavit of merit is subject to dismissal without prejudice, but if such plaintiff fails to comply with the statute of limitations, the action is dismissed with prejudice. *Scarsella*, *supra* at 549-550.

MCL 600.2912d(1) requires the affidavit of merit to state:

> (a) The applicable standard of practice or care.
>
> (b) The health professional's opinion that the applicable standard of practice or care was breached by the health professional or health facility receiving the notice.
>
> (c) The actions that should have been taken or omitted by the health professional or health facility in order to have complied with the applicable standard of practice or care.
>
> (d) The manner in which the breach of the standard of practice or care was the proximate cause of the injury alleged in the notice [of intent].

A defective and nonconforming affidavit of merit does not toll the statute of limitations. *Kirkaldy v Rim*, 266 Mich App 626, 634-635; 702 NW2d 686 (2005); *Mouradian v Goldberg*, 256 Mich App 566, 573-574; 664 NW2d 805 (2003). In *Mouradian*, this Court found that the affidavit of merit was grossly nonconforming because it failed to certify that the defendant breached any standard of care regarding the surgery in question, and the affidavit's only statements regarding the surgery concerned other defendants. *Id.* at 573.

The same conclusion applies here. The February 21, 2003, affidavit of merit contains only a single paragraph concerning Kindred: "Plaintiff [sic] suffered a G.I. bleed at Vencor which caused another stroke, another coma, and left side paralysis. Defendant Dr. Mulpuri failed to adequately monitor Sarah." In another paragraph, Dr. White groups Dr. Mulpuri with the HFHS physicians, and purports to state a standard of care for all of them:

> The applicable standard of practice required that physicians, including . . . Dr. Hojjat Shamloo, Dr. Mohammed, Dr. Raghu K. Mulpuri, Dr. Rajat Prakash, and Dr. Aref Amro, properly diagnose and treat the conditions then and there existing of Sarah Franklin and to provide the appropriate diagnostic tests, treatment, referrals, and monitoring in a timely manner.

This statement is very general and fails to state with sufficient particularity the standard of care applicable to Dr. Mulpuri. Even if the foregoing paragraph may be construed as an adequate statement of the standard of care applicable to Dr. Mulpuri, Dr. White's affidavit fails to state: (1) the actions Dr. Mulpuri should have taken or omitted in order to comply with the standard of care; (2) how any negligent conduct by Dr. Mulpuri caused harm to decedent; and (3) that Dr. Mulpuri did, in fact, breach the standard of care. All of these are required by MCL 600.2912d(1). Accordingly, the affidavit of merit was grossly nonconforming. Plaintiff's claim against Kindred is barred by MCL 600.2912d(1), plaintiff failed to commence an action against Kindred under MCL 600.5805, and his claim is therefore time-barred by the statute of limitations. *Scarsella, supra* at 552-553. The trial court erred as a matter of law in failing to grant Kindred's motion for summary disposition under MCR 2.116(C)(7).

We affirm the trial court's grant of summary disposition on the medical malpractice claim, the direct and vicarious liability claims, and the claims against the social workers. We reverse the denial of summary disposition to Kindred under MCR 2.116(C)(7). This case is remanded for entry of an order granting Kindred's motion for summary disposition. We do not retain jurisdiction.

/s/ Christopher M. Murray
/s/ Kathleen Jansen
/s/ Kirsten Frank Kelly